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Strengths and weaknesses of midwifery care from the perspective of women

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ABSTRACT

Background. Since users of healthcare services can be regarded as experts by experience, their views and judgements on quality of care are of paramount importance to care-providers who seek to improve or evaluate their services.

Aim. To explore client experiences of midwifery care, and to propose recommendations regarding the development of quality assessment and improvement programmes.

Method. As part of a larger study to monitor midwifery care in the Netherlands, women's views on the care they received were explored and described. Data were obtained from 358 women visiting a representative sample of 57 midwifery practices in the Netherlands. They completed a written questionnaire approximately six weeks after the birth of their baby. This questionnaire addressed various aspects of prenatal, perinatal and postpartum periods and contained two open-ended questions. The responses to the open-ended questions were analysed by clustering coherent responses into quality of care themes derived from previous research into this area.

Results. Courtesy and professional competence in midwifery care were most valued by women. Especially appreciated were a personal approach, especially during birth, a midwifery practice that is easily accessible by telephone and having enough time during appointments. Most weaknesses were found in the dimensions of organisation, policy and information. With respect to improving the quality of care from the perspective of pregnant women, clients reported that midwives should focus on continuity of care, a thorough evaluation of care and reducing the time women spend in the waiting room.

Conclusion. The strengths and weaknesses of midwifery care identified in this study, as perceived by the women who use maternity services, could contribute to the improvement of client satisfaction and to the ability of midwives to provide client-centred care.

INTRODUCTION

Quality of care is important to all parties involved in healthcare services – clients, care-providers, health insurers and governments (Carr-Hill, 1992). Since users of healthcare services can be regarded as experts by experience (Waal van der et al, 1996), their views and judgments on quality of care are of paramount importance to care-providers who seek to improve or evaluate their services (Sixma et al, 1998).

As perceptions of women and midwives differ regarding the quality of maternity services (Proctor, 1998), it is necessary to involve clients in service improvement. The opinion of women can help care-givers change practices in ways that will benefit future clients (VandeVusse, 1999).

Other studies have been conducted regarding the quality of midwifery care in which women have been consulted (Brown et al, 2005; Spiby et al, 2003; van Teijlingen et al, 2003; Sadler et al, 2001; VandeVusse, 1999; Lavender et al, 1999; Shields et al, 1998; Proctor, 1998; Bluff and Holloway, 1994). However, most of these studies focus on only one aspect of the quality of care or measured women's satisfaction. In contrast, this study focused on the quality of midwifery care as a whole, including prenatal, perinatal and postnatal care, assessing a large sample of women's positive and negative experiences.

The findings of the study described in this article are based on two generally accepted ideas in quality of care research. First, service quality is defined according to Parasuman et al, as 'a function of the magnitude and direction of the difference between expected and perceived service' (1983: 46). This assumes performance can be measured by problem frequency. Low problem frequency is associated with good performance by care-providers and with good quality of care, whereas high problem frequency is associated with relatively poor performance and with poor quality of care (Zastowny et al, 1995). So, asking clients about their positive and negative experiences of care can provide valuable information about quality of care from the perspectives of clients.

Second, service users' judgments of quality of care are generally agreed to be multidimensional, relating to aspects including courtesy and information (Hall et al, 1988; Zastowny et al, 1995). Research in this area should, therefore, use a multidimensional approach. The aim of this article is to determine:

- Which aspects of the quality of midwifery care are appreciated most by clients
- Which aspects of the quality of midwifery care can be improved, according to women
- How the experiences of women can be utilised in the quality assessment and quality improvement programmes of individual midwifery practices.

BACKGROUND

Obstetric care in the Netherlands is provided by primary caregivers (midwives or GPs) and by secondary care-givers (specialist obstetricians). Women with low-risk pregnancies receive care from midwives or sometimes from GPs. When they remain low risk throughout pregnancy (57% of all pregnant women in the Netherlands in 2002) they are free to decide for themselves where they want to give birth, at home or in hospital (short stay), assisted by their own primary caregiver. Referral to specialist care will only take place if there is a risk of complications. The home birth rate in 2002 for the total Dutch childbearing population was approximately 30%, and for women who remained low risk throughout pregnancy and delivery, it was approximately 70% (Anthony et al, 2005). Of women who began their delivery, assisted by a primary care midwife, 52.2% of respondents in 2002 gave birth at home (Anthony et al, 2005).

Since 1990, representatives of clients, care-providers, health insurers and the government in the Netherlands meet each other formally on a regular basis in 'Leidschendam conferences', where they discuss how quality of care can best be improved. In the Netherlands, all of these parties agree that healthcare services should be based on demand rather than availability (Borst-Eilers, 2001; Oudenampsen, 1999).

Midwives in the Netherlands also seek to maintain and improve the quality of their services and organisation, and the Royal Dutch Midwifery Association (KNOV) is working on a quality system in order to contribute to the systematic improvement of the organisation and the provision of midwifery services. This includes demand-based care (Royal Dutch Midwifery Association, 2005).

METHOD

Data were drawn from the 2004 monitor midwifery care (MMC) survey – a nationwide random sample survey representing all midwifery practices in the Netherlands (Wiegers et al, 2002). The research period in each of the 70 participating midwifery practices was three weeks. During this period, participating midwives were asked to register the time they worked and to complete some additional questionnaires. Another element of the research consisted of the distribution of client questionnaires to women whose midwifery care had recently ended.

In the Netherlands, most women visit their midwife approximately six weeks after the birth of their baby to evaluate and complete their period of midwifery care. During the three weeks research period

in the participating midwifery practices, midwives were asked to hand out the client questionnaires to all women who paid this conclusive visit to their midwifery practice. Access to women was therefore secured via the midwives who participated in the MMC survey. As women were free to decide whether they wanted to participate in the research or not, their names and addresses were not released by midwives and data were processed anonymously, there was no requirement in the Netherlands for this research to be passed by an ethics committee.

The study was conducted in the second half of 2004. In total, 358 young mothers from 57 midwifery practices completed and returned the questionnaire, and there was no follow up with them. As the researchers were dependent on the midwives to hand out the questionnaires, the exact response rate was unknown. Assuming that all eligible women visiting the participating midwifery practices during the research period received a questionnaire, the response rate was 64%. When only midwifery practices from which at least one client questionnaire was returned to the Netherlands Institute for Health Services Research (NIVEL) are included, the response rate was 81%.

The questionnaire addressed various aspects of the prenatal, natal and postpartum periods and contained two open-ended questions:

- 'Considering your experiences with your midwife and the midwifery care you received, are there aspects you appreciated most about the midwifery care you received? Please mention two to five of these aspects'
- 'Considering your experiences with your midwife and the midwifery care you received, are there any aspects of which you say: 'that could have been arranged differently' or 'according to me, this aspect leaves room for improvement'? Please mention two to five of these aspects.'

These two questions resulted in a list of quality of care aspects that were analysed in the exploratory descriptive research outlined in this paper.

Some of these women answered the questions with key words, others answered in a narrative or descriptive way. In the latter case, a researcher coded the answer into one or more quality aspects, which were subsequently clustered into quality of care dimensions. These quality of care themes were derived from previous research on the quality of care from the patients' perspective (Nederlandse Patienten en Consumenten Federatie, 1996; Sixma et al, 1998). The eight main themes used to classify answers were professional competence, information, courtesy, support, perceived autonomy, organisation, accommodation and evaluation. During the clustering of the data, some of the remarks women made could not be assigned to one of the eight existing themes and therefore the additional category of policy was created, in which comments regarding ultrasound scans and appointment scheduling were included. When there was any doubt regarding the classification of a specific aspect, discussion between the two researchers took place until consensus was reached about the most appropriate dimension to assign the aspect to.

Finally, the number of comments collected about each aspect and dimension of the quality of care were counted.

FINDINGS

The home birth rate of the 358 respondents in this study was 49%, and ages ranged from 19 to 43 (mean=31.1). Nearly half of the women were primiparae and 48% had been educated to at least VWO-level (equivalent to British GCE Alevels). No information was available about the nationality or ethnicity of the respondents. For these background variables (age, parity and level of education), the research population was comparable to the general childbearing population in the Netherlands (Anthony et al, 2005).

Of the 358 women who returned the questionnaire, 312 (87.2%) listed 870 aspects that they appreciated about the midwifery care they had received (see Table 1). Courtesy (337 positive remarks made), professional competence (224 positive remarks made), and support (57 positive remarks made) were regarded by the women as strengths in the midwifery care.

[TABLE 1]

A total of 177 (49.4%) women responded to the question regarding aspects of their experiences of midwifery care that clearly left room for improvement. They mentioned 301 aspects that were open for improvement (see Table 2). The most frequently mentioned weaknesses of midwifery care were found

in the dimensions of organisation (65 negative remarks made), policy (62 negative remarks made), and information (46 negative remarks made).

[TABLE 2]

Interpretation of individual aspects

The majority of respondents were positive about midwives having a personal approach (89 positive remarks made), their approachability by telephone or otherwise (61 positive remarks made) and the amount of time available during appointments (59 positive remarks made).

According to the respondents, most attention should be paid to the continuity of care (25 negative remarks made). Other aspects of care that respondents said needed to be improved were decreasing the waiting times in the waiting room (23 negative remarks made) and increasing the number of ultrasound scans (19 negative remarks made).

Illustrative quotes referring to the main issues mentioned by the women were also selected (see Box 1).

[BOX 1]

Professional competence

The positive remarks about midwives' professional skills and competencies concerned a personal approach during labour and their ability to reassure the respondents when necessary. Relatively few negative remarks about this quality of care dimension were made compared to positive remarks.

Most of the negative remarks (n=5) dealt with a lack of physical examinations during check-ups.

Information

Women indicated that in some situations a lack of information led to (unnecessary) feelings of insecurity. For example, this occurred when women were referred to a gynaecologist. Some respondents would have liked to be given more information about the content of their consultations, their pregnancy in general, the different (alternative) ways to give birth, diets, laboratory results and the growth stages of their baby.

Mixed feelings were expressed concerning the attention paid to breastfeeding – women valued extensive information, but did not want their midwife to put them under pressure to breastfeed. Some respondents indicated they had the feeling they were forced to start or continue breastfeeding even if they decided for themselves they wanted to bottle-feed.

Courtesy

Regarding the courtesy of midwives, respondents highly valued quality aspects such as a personal approach, the amount of time, the interest shown in the client, the confidence women have in their midwives and their patience and calmness. The opinion of 89 women concerning the midwife's personal attention is illustrated in the following quote from one of the respondents:
'It was a pleasure visiting my midwife again. She gave good advice and was very supportive. The personal attention she gave me has definitely contributed to the nice memories I still have concerning the birth of my child. That is something that is worth its weight in gold' (midwifery practice 32, respondent 4).

Support

The support given by midwives was stressed by 31 women as positive. Midwives were able to reassure respondents they had normal pregnancies and that they were doing fine.

A total of 24 respondents indicated that reducing the number of midwives a woman sees improves the overall support the patient received. As women saw the same midwife more often, they could relate to them better, which according to the women improved the quality of care. If they saw too many midwives, it was not always clear for women which one would be present during the birth. Other disadvantages of seeing more than one midwife were the difficulty for them and the woman to get to know each other well, and the need to tell the same story over and over again.

Organisation

Although women valued the amount of time available for their own consultations, they did not want to spend too much time in the waiting room. Accessibility by telephone for both urgent and non-urgent questions was judged to be important, and this service was mentioned regularly in the positive comments as well as the negative comments.

Evaluation

Respondents stressed the need for a follow-up appointment with the midwife who was present during delivery. In their view, midwifery practices sometimes underestimated the importance for women that the midwife present during the delivery was also the midwife performing postpartum visits.

Policy

Four of the top ten aspects that need improvement, according to clients, refer to the policy dimension – the number of ultrasound scans, more check-ups in the first period of the pregnancy, more time available for each consultation and the availability of an ultrasound scanner at each midwifery practice. Some respondents (n=19) felt they did not receive enough ultrasound scans (at the time of the study only one scan was included in regular midwifery care). According to the respondents, reasons for an extra scan included 'to follow the health and growth of the baby' and 'to be prepared if the baby lies in breech position'. Respondents preferred that this scan was done at the midwifery practice itself, rather than elsewhere. Others (n=17) commented on the timetable of appointments. They wished they could visit their midwives more often, especially during the first period of their pregnancy when the unborn baby was still quiet to make sure it was healthy and still alive. According to these respondents, more frequent visits would contribute to better preparation for parenthood.

IMPLEMENTATION OF WOMEN'S FEEDBACK

Providing women-centred care entails asking the opinion of users of midwifery care on a regular basis. Re-evaluation is necessary to review and monitor changes in quality standards, to evaluate service changes and innovations and to compare different (international) settings regarding their priorities and perceptions. The results of this study could be used as a start towards the development of an instrument to gauge quality of health care from the perspective of women using midwifery services. Such an instrument could provide specific quantitative information for practical quality assurance policies. Other measuring instruments for specific groups of care-users already exist (Eijk et al, 2001; Hekkink et al, 2003; Nijkamp et al, 2002; Sixma et al, 1998; Sixma et al, 2000; van Campen et al, 1997). With such an instrument, re-evaluation of midwifery care from the perspective of women would be achievable. The method of this instrument's development could also be used in other countries, as it takes account of country-specific factors. Ideally, the instrument could also be used for international comparisons.

Clearly, not all results of this study are applicable to all practices, to all individual midwives within a practice or to other care-providers involved in giving care around childbirth. Together with colleagues, other care-providers and clients, individual midwives as well as midwifery practices should consider for themselves whether they recognise the remarks made by the respondents. When individual midwives are able to acknowledge the strengths and weaknesses in their own practice, a strategy can be developed regarding the implementation of improved patient-centred care, which is not only consistent with KNOV quality policy, but also with 'the framework of decision-making in midwifery care' of the International Confederation of Midwives (2005b).

DISCUSSION

Although the women participating in the survey are representative of women who use maternity care in the Netherlands according to the background variables of age, parity, and level of education, they are not representative with respect to the risk of complications. Women who visit midwifery practices are mainly, but not always, a primary care population and more than average experience an uncomplicated pregnancy, delivery and puerperium, as women at high risk of complications visit a gynaecologist most of the time. Nevertheless, the results of this study are applicable to the relatively low-risk childbearing population in the Netherlands.

The themes to which the women's remarks have been ascribed in this study are generally accepted and often used in literature as quality of care themes. For most aspects, it was clear to which quality of care theme to assign them, but for other aspects this was more difficult. For example, should the aspect 'good and personal attention during birth' be ascribed to the quality of care theme of support or of professional competence? During the clustering, considered decisions were made for a certain theme, but in interpreting the results, it should be kept in mind that the divisions between the quality of care themes are not as strict as assumed in this study.

As a new questionnaire was designed for this study, it is hard to vouch for its reliability and validity, but there are three indicators that plead for its validity:

- Clients were involved in the development process
- Quality of care was approached multi-dimensionally and using the same quality of care dimensions as used in other research in this field
- The results of this study were in line with those that could be expected on the basis of the literature (van Teijlingen et al, 2003; Hekkink et al, 2003; Nijkamp et al, 2002; Sixma et al, 1998; Sixma et al, 2000; van Campen et al, 1997; van Campen et al, 1998).

For further development of the reliability of the tool, a testretest design is advisable.

It was difficult to compare midwives with other careproviders because, in general, the reason women visit a midwife is a pleasant one. One of the reasons that respondents tend to answer positively to questions about overall satisfaction is a reluctance to criticise their care-givers (Fitzpatrick, 1991; van Teijlingen et al, 2003). In this study, almost 50% of all women who returned the questionnaire answered the question on aspects they disliked about their midwifery care, while approximately 90% could mention at least one aspect that they liked. However, this does not mean that midwives cannot learn from the suggestions made by their clients – healthcare professionals should actively contribute to the maintenance or improvement of the quality of their services.

SUMMARY

The aim of this study was to explore patient satisfaction with midwifery care, and to propose recommendations regarding the development of quality assessment and quality improvement programmes in the field of midwifery. It revealed midwifery-specific as well as non-specific quality of care aspects. Examples of midwifery-specific aspects were the number of ultrasound scans and the role of the midwife during delivery. Examples of non-specific quality of care aspects were the time spent in the waiting room and the amount of information received by clients. The results of this study are consistent with those of other studies that measure satisfaction from the perspective of a specific group of clients or patients (Smit and Friele, 2005; Hekkink et al, 2003; Nijkamp et al, 2002; Sixma et al, 1998; Sixma et al, 2000; van Campen et al, 1997; van Campen et al, 1998).

The results of this research show that according to women, midwives perform well on the dimensions 'courtesy' and 'professional competence'. Strengths in midwifery care are for there to be a personal approach, the fact that midwives are available for questions and take time for consultations. Furthermore, women praised their midwives for their personal approach during delivery, their skilfulness and professionalism, and their ability to ease their minds by assessing situations correctly.

Efforts to improve the service quality of midwifery practices and to bring services more in line with the wishes of users should focus on policy, the provision of information and evaluation. Attention has to be paid to aspects such as continuity of care, time spent in the waiting room, the perceived low number of ultrasound scans, low frequency of consultations in the first period of pregnancy and the quality as well as amount of information midwives provide spontaneously.

Finally, this paper has identified a possible way to implement feedback from childbearing women in the quality assessment and quality improvement programmes of individual midwifery practices with the aid of an instrument that can also be used with an international perspective.

TABLES AND BOXES

Table 1. Most frequently mentioned aspects of care that women appeciated (top ten rank)

Dimension/aspect	Times mentioned
Professional competence	**224**
Good, personal attention during birth (4)	47
Skilful and professional (5)	44
Easing the woman's mind/assess the situation correctly (6)	41
Continuity of care	25
Taking extra precautions in case of doubt	19
Providing good care	16
Paying attention to the wellbeing of mother and baby	12
Information	**50**
Clear and good provision of information	24
Providing sufficient information	10
Courtesy	**337**
Personal approach (1)	89
Providing sufficient time during appointments (3)	59
Showing interest in the client (7)	36
Reliable/confident (8)	36
Always patient and calm (9)	33
Pleasant company	29
Listening to the woman's concerns	17
Frank/open/honest/accurate	11
Support	**57**
Good support (10)	31
Involving partner/children in the care process	12
Perceived autonomy	**60**
Taking the woman seriously/being appreciative	21
Involving the woman when important decisions are to be made	13
Organisation	**107**
Easy to reach by telephone/easy to reach for questions (2)	61
Communicating well with other midwives	16
Quickly present for the delivery	14
Quality of facilities	**3**
Evaluation	**26**
Good postnatal follow-up service	26
Policy	**6**

Only aspects mentioned by at least ten respondents are listed, though the totals for each dimension include all aspects mentioned by the women.

Table 2. Most frequently mentioned aspects of care that the women thought could be improved (top 12 rank)

Dimension/aspect	Times mentioned
Professional competence	**24**
More physical examinations during check-ups	5
Information	**46**
Offering more information without the client having to ask (5)	13
Providing more information about different ways to give birth/delivery (6)	11
Providing more information about breastfeeding	5
Courtesy	**34**
Understanding the woman more (8-12)	8
Less strict/capricious	6
Less insistent about breastfeeding	5
Support	**41**
To be seen by more than one midwife/continuity of care (1)	25
Perceived autonomy	**9**
To work with fewer stand-ins	6
Organisation	**65**
Waiting for less time in the waiting room (2)	23
More accessible by phone for non-urgent questions (8-12)	8
Improved referral to other healthcare workers	6
Quality of facilities	**4**
Evaluation	**16**
Discussing the delivery with the midwife who was present during delivery (8-12)	8
Less brief follow-up consultation (8-12)	8
Policy	**62**
More ultrasound scans (3)	19
More check-ups in the first period of the pregnancy (4)	17
More time available for each consultation (7)	9
Ultrasound scans at the midwifery practice (8-12)	8

Only aspects mentioned by at least five respondents are listed, though the totals for each dimension include all aspects mentioned by the women.

Box 1. Illustrative remarks made by respondents (midwifery practice number/respondent number)

Professional competence
'She was really a pillar of strength during the delivery. She told me what to do, encouraged me, kept eye contact with me and had a lot of self-confidence.' (20/2)
'I guess I wanted more examinations.' (36/1)
'She could have checked my blood and urine more often.' (47/15)
Information
'I would have liked to receive more information about the different ways to deliver a baby and about the possible equipment (bath, birthing stool, etc).' (18/12)
'My midwife referred me to the hospital because of the possibility of me having pregnancy diabetes. I was worried about this referral, which would not have been necessary if I was better informed.' (52/15)
Courtesy
'My midwife allowed me enough time, even though there were other women waiting in the waiting room.' (7/1)
'My midwife pressured me too much to breastfeed. I did not receive enough information about bottle-feeding to make an appropriate decision for myself.' (23/4)
Support
'They know how to encourage you, especially when you feel miserable, moreover they were very supportive and took away some of my fears and insecurities.' (36/1)
'I saw different midwives within the same practice. The disadvantage was that I was not able to build up a relationship with one of them.' (43/11)
Organisation
'She gave me the feeling that I could call her in case of emergency or whenever I felt insecure, even if it was in the middle of the night.' (43/6)
'In case of emergency, the midwives were very accessible. For non-urgent questions, however, you could only call them during one hour twice a week. When you wanted to call them during these consulting hours, the telephone was engaged a lot of the time.' (40/6)
Evaluation
'The last visit was performed by a midwife I did not know. Although the visit was satisfying, I would have preferred a familiar midwife. She knows me and my situation better and is more able to assess my situation correctly.' (19/7)
'The support of the midwife, the maternity care assistant, the district nurse and the lactation specialist after my baby was born was terrific. The attention that was paid to me and my baby was a very pleasant experience.' (32/1)
Policy
'My midwife did not diagnose the breech position of my baby. In my opinion, it would be a good idea for a standard ultrasound scan to be performed during the last period of the pregnancy.' (33/15)
'Especially in the beginning of the pregnancy, when you cannot feel the baby move, a period of one month between visits to the midwife is really long. It would be good to pay a visit every three weeks, just to make sure the baby is still alive.' (17/6)

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